hypothesize that patients with Chronic Kidney Disease compared with non-Chronic Kidney Disease have reduced platelet aggregation and poor platelet inhibitory response to DAP (aspirin and clopidogrel).

Methods: In this study we have studied 210 patients with CAD who underwent PTCA and started on aspirin and clopidogrel 75 mg twice a day. Platelet aggregation test was performed in all patients after 15 days. Estimated GFR is calculated in all the patients according to MDRD formula. Patients were classified into 4 categories. Group 1with GFR >90, group 2 with GFR 60-90, group 3 with GFR 30-60, group 4 with GFR <30. The effect GFR on platelet inhibition is studied in all groups.

Results: 210 patients who underwent PTCA who are included in this study 166 were male patients and 44 were female patients. Among them 72 were non hypertensives and 138 were hypertensives. Diabetes is seen in 89 patients and 129 patients were non diabetics. Out of the 210 patients 75 were present and ex-smokers 135 were non smokers. Among the study population 20 were alcoholics and 190 were non alcoholics. Only 5 patients in the study population had a significant family history of CAD. 93 patients who underwent PTCA presented with acute coronary syndrome (ACS) whereas 117 patients presented with chronic stable angina (CSA). 142 patients who underwent PTCA had good LV function, 32 had mild LV dysfunction, 12 had moderate LV dysfunction and 24 severe LV dysfunction. 20 patients had a history of CABG done in the past. 102 patients underwent the procedure through femoral route and 108 patients through the radial route. 7 CTO lesions were found and 150 type B2 lesions, 8 type B1 lesions, 27 type C lesions were found.

The mean age in the study population is 55.12+10.5 yr. The mean haemoglobin level in the study population of is 12.9+2.09 gm %. The mean TLC count was 9039+2840/ mm^3. The mean platelet count was 2.4228+0.8065 lakhs. The mean total cholesterol level is 138.08+40.33gm/dl. The mean LDL level was 71.08+33.94gm/dl. The mean HDL level was 41.15+12.94gm/dl. The mean VLDL level was 26.40+14.53gm/dl. The mean TG level was 124.76+72.05gm/dl. The mean height was 157.85+ 8.32 cm. The mean weight was 63.935 +9.697 kg. The mean stent size was 2.8220 +0.3077 mm. The mean LP $_{(a)}$ level was 54.84 +59.38. The two sample t test does not show any significant difference between the group with normal GFR and those with decreased GFR. The regression analysis revealed significant difference in p value in smokers and longer stent length.

Conclusions: CKD patients showed effective platelet inhibition post PTCA with clopidogrel after 14 days and there is no need of change in the antiplatelet regimen for these subset of patients. There is no statistically significant difference in patients with CKD and normal GFR. Only stent length and smoking significantly influence platelet inhibition in this subset.

A study of correlation of red cell distribution width with the severity of coronary artery disease

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Background: Red cell distribution width (RDW) is a measure of the variability in the size of circulating erythrocytes, commonly utilized in the differential diagnosis of anemia. It has been shown that RDW is closely related to the prognosis and long term adverse events of cardiovascular diseases. The aim of the present study was to prospectively evaluate the severity of coronary artery disease by angiography and RDW at Osmania General Hospital, Hyderabad.

Methods: A total of 132 consecutive patients who were admitted into cardiology department due to the presence of typical angina and/or positive treadmill test and underwent coronary angiography were enrolled in the study .Based on the results of the coronary angiography the patients were divided into two groups, CAD group (n=105) and control group (n=27).The severity of CAD in each patient after angiography was evaluated by Modified Gensini score, and its relationship with RDW was analyzed.

Results: On analysis, the mean age of patients with CAD was 51.74±11.20yrs and in controls was 48.22 ± 9.51 yrs. Male :Female ratio was 3.03:1 (n=79,n=26).In patients with CAD smokers constituted about 53.3%(n=56),diabetics were about 32.3%(n=34),those with hypertension were 68.57%(n=72).family h/o CAD was seen in 21%(n=23).In patients with CAD, mean Hb was 13.4±1.4,mean RDW was 16.62±1.47 where as in controls the mean Hb was 13.1±1.2,mean RDW was 14.37±1.55.There was significant correlation of RDW in patients with high Gensini score(>13) by ANOVA analysis (p=0.05). RDW correlated with severity of CAD when the Gensini score was >6.

Conclusion: RDW is associated with both presence of CAD and severity of coronary stenosis. It can be a readily available, economical marker for the prediction of CAD. A High RDW predicts a significantly severe CAD on angiography.

Eptifibatide in Post Infarction angina who Refused for Intervention: AJMer post infarction angina Eptifibatide Research (AJMER) study: A Pilot Study

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Background: Postinfarction angina is not an uncommon complication after myocardial infarction (MI). Because of its high risk score (Unstable angina class III; Risk score 9 if rest angina<48 hours post MI), guidelines recommend early intervention in these patients. However, financial constraints and lack of wide insurance coverage in developing countries prohibit intervention in deserving patients. We sought to analyze whether addition of eptifibatide (which acts by inhibiting platelet aggregation, a key mechanism in postinfarction angina) would add to the benefit achieved by intensified antianginal therapy alone in patients with postinfarction angina unwilling for intervention.

Methods: 461 patients of postinfarction angina who refused to undergo early intervention were assigned in a 1:1 manner to receive either eptifibatide (180 μg/kg bolus followed by 2.0 μg/kg/min infusion for 24 hours) along with intensification of antianginal therapy (Group A; n=229) or intensified antianginal therapy alone (Group B; n=232). The primary end points were composite of all cause death and non fatal myocardial infarction at 30 days.

Results: Primary composite end points did not differ between the two groups (16.2% versus 18.9% in group A and group B, odds ratio [OR], 0.82; 95% confidence interval [CI], 0.5-1.30; p value= 0.43).Recurrent angina was lower in the group A (8.3% versus 17.7%; OR, 0.42; 95% CI, 0.27-0.75; p value= 0.003). Total time to reach pain free status (as measured by patient on visual analogue scale) was lower in the group A when compared to the group B

(p value =0.05). On bleeding academic research consortium (BARC) scale, type 1 and 2 bleeding were higher with eptifibatide (OR, 3.18; 95% CI, 1.76-5.74; p value= 0.0001), however the more serious (composite of type 3 and 5) bleeds did not differ between the two groups (OR, 1.73; 95% CI, 0.7-4.08; p value= 0.21).

Conclusion: Patients with postinfarction angina, unwilling for intervention, had reduced incidence of recurrent angina and earlier relief of anginal symptoms, when eptifibatide was added to intensified antianginal therapy. This, it achieved without causing significant difference in the primary composite end points. Although significant increase was noted in types 1 and 2 BARC bleeding in the group A, incidence of higher degree bleeds did not differ significantly between the two groups.

Impact of pre infarction angina (PIA) in STEMI outcome in the current era

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Background: Mortality of STEMI even in the current coronary intervention era is 7-8%. The relationship between pre infarction angina (PIA) and mortality has been studied in the past. However factors that determine favorable outcome in preinfarction angina have not been studied in our population. In this context, this study has been done to evaluate the relationship between preinfarction angina and its beneficial effect in STEMI outcome.

Aim: To evaluate outcome of pre infarction angina in STEMI patients, related to CK-MB level, baseline

LV function on admission and in-hospital outcome and mortality.

Methods: Non Randomized Observational (Prospective Study) Study Period – July (1-31) 2014.

STEMI Patients Admitted In CCU

Inclusion criteria: 1. All AWMI as a first ACS event (acute or recent not old) irrespective of comorbid conditions and risk factors 2. All AWMI lysed (or) treated by conservative management

Results: Total no of patients observed n=29. Out of these PIA present in 10 patients. PIA absent in 19 patients. CK-MB median level after admission was lower in PIA positive group. Baseline LV function was also better in PIA postive group (median EF = 45%). Complications like Arrythmia, Cardiogenic shock and freewall rupture were absent in pia positive group. Mortality was also nil PIA positive group.

Conclusion: Presence of preinfarction angina in anterior STEMI is associated with lower in-hospital mortality, better LV-function and preserves electrical stability in our population.

Correlation between the magnitude of T wave inversion with IRA patency following thrombolysis in STEMI

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Objective: This study was undertaken to correlate the magnitude of T inversion following thrombolysis in acute STEMI with Infarct Related Artery (IRA) patency.

Background: Although many studies have demonstrated the association between early T wave inversion after thrombolysis and angiographic patency, T wave inversion magnitude after successful lysis with resolved ST segment was further evaluated in relation to IRA patency.

Methods: This is a prospective observational study done during the month of April 2014 in tertiary care hospital. A total of twenty patients, age ranging from 32 to 60 yrs with anterior and inferior wall STEMI who were treated with I.V streptokinase as per protocol on admission and predischarge coronary angiogram was done within 5 days of admission . Patient stratification was done based on the depth and width of maximally inverted negative T waves, ejection fraction and it was correlated with angiographic patency of IRA.

Results: Among the twenty patients, recanalised IRA was found in 2 patients who had more broad and deeply inverted T waves in ECG. In the remaining 18 patients, deeper inverted T waves in 12 patients was associated with better patency rate of IRA(70% vs 30%), lower peak CPK value (250+/_50 vs 400+/-100) better EF (50+/_10% vs 35+/_5%) than the 6 patients who had small inverted T waves .

Conclusion: Early T wave inversion as quoted earlier has good correlation with IRA patency. Also some correlation was found between quantum of T wave inversion with IRA patency. However, this was not linear and further studies are required.

Tailored thrombolytic therapy for ST-elevation MI (STEMI) in very elderly patients

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Background: The optimal reperfusion strategy in very elderly patients (age >80years) with STEMI still remains a topic of debate. This may largely be attributed to omission / under-representation of the very elderly in clinical trials. Tailored thrombolytic therapy (TLT) may be an appropriate option for such selected individuals, even in this era of primary PCI. Here, we present our single-unit experience in tailored thrombolysis for very elderly over the last 5 years.

Materials and Methods: We did 8 cases of reperfusion therapy in the very elderly over the last 5 years. There were 5 males and 3 females and were in the age group of 80 – 90 years. 5 patients presented with acute IWMI and 3 patients with acute AWMI. 3 patients had creatinine levels > 2 mg/dl. 3 patients were underweight (<50 kg), 2 patients had COPD and 2 patients had gastritis. The options of primary PCI and thrombolytic therapy were discussed; after which, 3 patients opted for primary PCI and stenting. The remaining 5 patients were discussed regarding conventional thrombolysis & tailored thrombolysis (TLT), and the higher risk of bleeding with conventional thrombolysis. They were then taken up for tailored thrombolytic therapy. The regimen included an initial IV Tenecteplase 0.25 mg/Kg (half-dose Tenecteplase) followed by assessment for resolution of symptoms (chest pain) and ECG changes of ST segment resolution at 30 minutes after TLT. If the first thrombolysis was unsuccessful, the remaining half dose of IV tenecteplase had to be given.